Laser Hair Removal Consent

I hereby authorize and direct my Medical Aesthetician and Edans Med Spa to perform laser assisted hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple laser procedures.

The following points have been discussed with me
• The potential benefits of the proposed procedure.
• The probability of success.
• The fact that I will need multiple treatments to achieve maximum results.
• The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to, infection, scarring, crusting, re-growth of hair, and/or blistering.
• Pre and Post care treatment instructions.

I am aware of the following possible experiences/risks with Laser Surgery
• DISCOMFORT – Some discomfort may be experienced during laser treatment.
• WOUND HEALING – Laser Surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
• PIGMENT CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
• SCARRING – Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
• EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NONREFUNDABLE. BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT.

Patient signature: _____ Date: _____

Clinician signature: _____ Date: _____